TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT
HOSPICE
2006

SCHEDULE A - IDENTIFICATION

1. Name of Hospice _____
2. Address: Street _____

   City _____ County _____

   State _____ Zip Code _____
3. Area Code _____ Telephone Number _____
4. Name of Owner _____ Race of Individual _____

   If owned by corporation or partnership give race of board.
   Number: White_____ Black_____ Other_____
5. Name of Administrator _____
6. Name of person(s) completing this form _____
7. Date of completion of form _____
   Month/Day/Year
8. Reporting period if different than July 1, 2005 - June 30, 2006.
   Beginning _____ Ending _____
9. If your organization has not been open for an entire 12 month period, please specify the number of days this report covers: _____ days

SCHEDULE B - CLASSIFICATION

1. Type of Ownership: (Check Only One)

Individual:	☐ Profit	☐ Non Profit	
Partnership:	☐ Profit	☐ Non Profit	
Corporation:	☐ Profit	☐ Non Profit	
Government:	☐ State	☐ County	☐ City
	☐ County/City	☐ Federal	

Other: (Specify) _____

2. Type of Organization (Check one and specify name of facility)

   ☐ Hospital Based (Specify) _____

   ☐ Nursing Home Based (Specify) _____

   ☐ Home Health Agency Based (Specify) _____

   ☐ Free Standing

SCHEDULE C - ACCREDITATIONS AND APPROVALS

1. Please indicate the type of accreditations, approvals, and memberships held by your organization.
(Check all that apply)

MEMBERSHIP	PAYOR PARTICIPATION	ACCREDITATION
☐ National Hospice Organization	☐ CHAMPUS	☐ Joint Commission on Accreditation of Health Care Organization
☐ Tennessee Hospice Organization	☐ TennCare	☐ Accredited by the National League of Nursing
☐ Tennessee Association for Home Care	☐ Medicare	
☐ THA Home Care Alliance		

☐ Other_____

SCHEDULE D - FINANCES

1. Please specify date of cost report or fiscal year used to complete items:_____
Month/Day/Year

2. Net Revenue By Revenue Source: Amount

A. TennCare	_____
B. Medicare	_____
C. CHAMPUS	_____
D. Private Pay	_____
E. Other Pay Source	_____
F. Charity Care	_____
TOTAL	_____

3. Total program costs for reporting period:
$_____

4. Medicare Per Diem Rates By Level of Care:

Routine Hospice Care	$_____
Continuous Hospice Care	$_____
General Inpatient	$_____
Respite Inpatient	$_____

SCHEDULE E - AVAILABILITY AND UTILIZATION OF SERVICES

Patients Served

1. Referrals
   A. Total number of referrals admitted to organization _____
   B. Total number of referrals not appropriate for admission _____

2. What is the unduplicated number of patients served by your organization during the 12 month reporting period? _____(Number of patients receiving services on day 1 of reporting period plus number of admissions for year.)

3. Discharges and total patient days by reason during 12 month reporting period:

Reason For Discharge	No. of Patients Discharged	Total Patient Days
Physician order (Unplanned)	_____	_____
Death	_____	_____
Patient request	_____	_____
Transfer out of service area	_____	_____
Revoked hospice benefit	_____	_____
Patient no longer met payor's hospice qualifications for eligibility/coverage criteria	_____	_____
Other	_____	_____
TOTAL	_____	_____

SCHEDULE E - AVAILABILITY AND UTILIZATION OF SERVICES (continued)

4. Please specify the total number of patients who received the services and the number of days or visits provided to those patients. For per diem payors, exclude number of visits.

Discipline	TennCare				Medicare		CHAMPUS			
	Per Diem		Per Visit				Per Diem		Per Diem	
	Patients	Days	Patients	Visits	Patients	Days	Patients	Days	Patients	Visits
Routine Hospice Care										
General Inpatient Care										
Continuous Care										
Respite Inpatient Care										
TOTAL										

Discipline	Private Pay		Other Payor				Charity	
	Patients	Days	Patients	Days	Patients	Visits	Patients	Days
Routine Hospice Care								
General Inpatient Care								
Continuous Care								
Respite Inpatient Care								
TOTAL								

5. Average Length of Stay (Unduplicated)

Hospice Services Patient:

All Patients _____
Medicare Patients _____

6. Volunteers

Total Number of Volunteers _____

Total Hours Served _____

7. Number of Visits by Discipline

RN/LPN _____
Social Worker _____
Chaplain _____
Hospice Aide _____
Therapies (PT,ST,OT,RT) _____
Other _____
TOTAL _____

8. Bereavement

a Total number bereavement cases hospice followed during reporting period _____

b. Bereavement Services offered (check all that are available)

____ Group Support
____ Children's Day Camp
____ Mailings
____ Individual Follow-up
____ Other, Specify_____
_____

SCHEDULE F – PATIENT UTILIZATION

Note: Total patients must agree in items 1, 2, 3, and 4 in Schedule F.

1. Total patients and days during twelve month reporting period by county of residence. Check box if licensed in this county.

TN County Residence	Number of Patients	Total Number of Days
☐ 1 Anderson		
☐ 2 Bedford		
☐ 3 Benton		
☐ 4 Bledsoe		
☐ 5 Blount		
☐ 6 Bradley		
☐ 7 Campbell		
☐ 8 Cannon		
☐ 9 Carroll		
☐ 10 Carter		
☐ 11 Cheatham		
☐ 12 Chester		
☐ 13 Claiborne		
☐ 14 Clay		
☐ 15 Cocke		
☐ 16 Coffee		
☐ 17 Crockett		
☐ 18 Cumberland		
☐ 19 Davidson		
☐ 20 Decatur		
☐ 21 Dekalb		
☐ 22 Dickson		
☐ 23 Dyer		
☐ 24 Fayette		
☐ 25 Fentress		
☐ 26 Franklin		
☐ 27 Gibson		
☐ 28 Giles		
☐ 29 Grainger		
☐ 30 Greene		
☐ 31 Grundy		
☐ 32 Hamblen		
☐ 33 Hamilton		
☐ 34 Hancock		
☐ 35 Hardeman		
☐ 36 Hardin		
☐ 37 Hawkins		
☐ 38 Haywood		
☐ 39 Henderson		
☐ 40 Henry		
☐ 41 Hickman		
☐ 42 Houston		
☐ 43 Humphreys		
☐ 44 Jackson		
☐ 45 Jefferson		
☐ 46 Johnson		
☐ 47 Knox		
☐ 48 Lake		
☐ 49 Lauderdale		
☐ 50 Lawrence		
☐ 51 Lewis		
☐ 52 Lincoln		
☐ 53 Loudon		
☐ 54 McMinn		
☐ 55 McNairy		
☐ 56 Macon		
☐ 57 Madison		
☐ 58 Marion		
☐ 59 Marshall		
☐ 60 Maury		
☐ 61 Meigs		
☐ 62 Monroe		
☐ 63 Montgomery		
☐ 64 Moore		
☐ 65 Morgan		
☐ 66 Obion		
☐ 67 Overton		
☐ 68 Perry		
☐ 69 Pickett		
☐ 70 Polk		
☐ 71 Putnam		
☐ 72 Rhea		
☐ 73 Roane		
☐ 74 Robertson		
☐ 75 Rutherford		
☐ 76 Scott		
☐ 77 Sequatchie		
☐ 78 Sevier		
☐ 79 Shelby		
☐ 80 Smith		
☐ 81 Stewart		
☐ 82 Sullivan		
☐ 83 Sumner		
☐ 84 Tipton		
☐ 85 Trousdale		
☐ 86 Unicoi		
☐ 87 Union		
☐ 88 Van Buren		
☐ 89 Warren		
☐ 90 Washington		
☐ 91 Wayne		
☐ 92 Weakley		
☐ 93 White		
☐ 94 Williamson		
☐ 95 Wilson		
☐ 96 Unknown Counties		
STATES		
☐ Alabama		
☐ Arkansas		
☐ Georgia		
☐ Kentucky		
☐ Mississippi		
☐ Missouri		
☐ North Carolina		
☐ Virginia		
☐ Other States		
TOTAL		

SCHEDULE F – PATIENT UTILIZATION (continued)

2. Number of patients by resident county and age during twelve month reporting period.

TN County of Residence	Age Groups 0-17 Yrs	18-64 Yrs	65-74 Yrs	75+ Yrs	Total
STATES					
Alabama					
Arkansas					
Georgia					
Kentucky					
Mississippi					
Missouri					
North Carolina					
Virginia					
Other States					
Totals					

SCHEDULE F – PATIENT UTILIZATION (continued)

3. Number of patients with diagnosis for the following:

Cancer	_____
Aids	_____
Other	_____
Total	_____

4. Number of patients by resident county and race during twelve month reporting period.

TN County of Residence	RACE White	Black	Other	Total
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
STATES				
Alabama	_____	_____	_____	_____
Arkansas	_____	_____	_____	_____
Georgia	_____	_____	_____	_____
Kentucky	_____	_____	_____	_____
Mississippi	_____	_____	_____	_____
Missouri	_____	_____	_____	_____
North Carolina	_____	_____	_____	_____
Virginia	_____	_____	_____	_____
Other States	_____	_____	_____	_____
TOTAL	_____	_____	_____	_____

SCHEDULE G - PERSONNEL

1. Number of employees, EXCLUDING volunteers providing service by type.

Type of Employee	Total Full-Time Equivalent*	Contract Full-Time Equivalent*
Administrators & Assistant Administrators		
Clinical Directors/Asst. Dir.		
Other Administrative Personnel		
Direct Nursing Services		
R.N.s		
L.P.N.s		
Physical Therapy Services		
Occupational Therapy Services		
Speech/Language Pathology Services		
Medical Social Services		
Respiratory Therapists		
Hospice Aides		
Homemakers		
Office Personnel (Clerical)		
Financial/Billing Personnel		
Medical Director		
Bereavement Counselor		
Other Counselors		
Nutritionist/Dieticians		
Chaplains		
Other (Specify):		
_____		
_____		
TOTALS		

FTE - Full-time Equivalents - (i.e. 40 hours = 1 FTE; 30 hours = .75 FTE; 20 hours = .5 FTE; 10 hours = .25 FTE.)

* To calculate FTE's - The sum of full-time employees plus part-time employees in full-time equivalent added together equal the total number of full-time equivalents.

SCHEDULE H – ALTERNATE SITES

1. Do you have alternate sites in other locations?

☐ Yes ☐ No

If yes, please provide names and addresses of alternate sites:

Name _____
Address _____
City/State/Zip _____
County _____

Name _____
Address _____
City/State/Zip _____
County _____

Name _____
Address _____
City/State/Zip _____
County _____

Name _____
Address _____
City/State/Zip _____
County _____

Name _____
Address _____
City/State/Zip _____
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County _____

Name _____
Address _____
City/State/Zip _____
County _____